Preliminary Problem Statement Assessment of Rhode Island Health Care System Planning Core Areas of Inquiry – Version 3

UPDATED WITH NOTES FROM THE DISCUSSION AT THE

Health Care System Planning Cabinet & EOHHS Independent Advisory Council Joint Meeting on April 30, 2024

AND RESULTS FROM THE FOLLOW-UP SURVEY

Updated May 20, 2024

Table of Contents

Introduction 4

Workforce 5

Initiatives to Build On – Existing Rhode Island Activities 5

Key Issues from the National Literature 6

Challenges drawn from RI Assessments/Reports/Key Informant Interviews 6

Primary Care 9

Initiatives to Build On – Existing Rhode Island Activities 9

Key Issues from the National Literature 9

Challenges drawn from RI Assessments/Reports/Key Informant Interviews 9

Oral Health 11

Initiatives to Build On – Existing Rhode Island Activities 11

Key Issues from the National Literature 12

Challenges drawn from RI Assessments/Reports/Key Informant Interviews 12

Behavioral Health 14

Initiatives to Build On – Existing Rhode Island Activities 14

Key Issues from the National Literature 14

Challenges drawn from RI Assessments/Reports/Key Informant Interviews 14

Equitable Access to Quality Services (capacity, vulnerable populations, disparities) 14

System Transitions, Integration and Coordination 15

Administrative Challenges, Policy Reform, and Accountability 16

Acute Hospitals 18

Initiatives to Build On – Existing Rhode Island Activities 18

Key Issues from the National Literature 18

Challenges drawn from RI Assessments/Reports/Key Informant Interviews 18

Long-Term Care 20

Initiatives to Build On – Existing Rhode Island Activities 20

Key Issues from the National Literature 21

Challenges drawn from RI Assessments/Reports/Key Informant Interviews 21

Challenges particular to Nursing Facility Sustainability and Financing: 21

Challenges tied to workforce across long-term care sector: 22

Challenges tied to gaps in the continuum of care: 22
Challenges tied to demographic/population issues: 23
Social Service 25
Initiatives to Build On – Existing Rhode Island Activities 25
Key Issues from the National Literature 25
Challenges drawn from RI Assessments/Reports/Key Informant Interviews 25

Introduction

The following information, organized by the planned Health Care System Planning Area of Inquiry, was originally developed primarily based on a review of existing Rhode Island health initiatives and State-developed reports, assessments, and research. (Please see sources of information in Appendix 1.) In addition, EOHHS' consultant JSI conducted a rudimentary review of ideas and concepts from the national literature.

This document should be seen as a draft summary of the initiatives this Rhode Island Health Care System Planning Process is building on, and the challenges that have been identified at the state and national levels.

EOHHS proposes to use this summary to guide our initial discussions to define problem statements for each Area of Inquiry and to prioritize Rhode Island's ongoing Health Care System Planning Process.

The next steps in this process are for the Health Care System Planning Cabinet, with input from the EOHHS Independent Advisory Council, to identify one to two areas for more thorough analysis toward a published report due on or about December 1, 2024, per Governor McKee's Executive Order of February 21, 2024.

UPDATE: This updated version of the Baseline Assessment includes the notes from the Joint Meeting of the Health Care System Planning Cabinet and the EOHHS Independent Advisory Council, held on April 30, 2024.

The notes are from the small group exercise that asked Cabinet and Advisory Council members to review the original document and make any additions or edits to the language.

New language appears in green font throughout the document.

UPDATE: This updated version of the Baseline Assessment includes the data from a follow-up survey completed by Health Care System Planning Cabinet members or members of the EOHHS Independent Advisory Council Joint Meeting.

New language appears in orange font throughout the document.

Workforce

Initiatives to Build On – Existing Rhode Island Activities

- Stakeholder engagement: 500+ people from 160+ organizations convened and aligned around The Rhode Ahead, EOHHS's Health & Human Services Workforce Initiative. The convening addressed shared workforce issues and problem approaches, including healthcare providers, trade and professional associations, education and training, labor and community organizations, policymakers, etc.; Third Annual Health Workforce Summit to be held on May 29
- Recruitment & retention: ARPA, enhanced HCBS FMAP, and GR/budgetary investments (one-time and on-going) to increase rates and wages across health & human services
- Health Professional Equity Initiative: EOHHS and OPC partnership to support paraprofessionals to pursue health professional degree and license
- Career pathways and Workforce Development Initiatives:
    - EOHHS and DLT investments in employer-driven workforce development partnerships to support job training, continuing education, career ladders/apprenticeships
    - Real Jobs Rhode Island (RJRI), demand-driven workforce and economic development initiative
    - EOHHS partnership with RIDE CTE and Adult Ed to increase pathways to employment for students and un/under employed youth and adults
    - Joint effort between AFLCIO and HARI to support workforce development
    - Expedited pathways for foreign-educated health professionals (Welcome Back Center)
        - Career pathway planning, employer networking, English language instruction, Re-credentialing and licensing support, acculturation support, and tutoring and licensing exam preparation
    - Some states, based on media reports, are making a direct financial investment in training CNAs. RI has used some one-time funding to do so via Healthcentric Advisors, but a broader and more significant financial effort would be beneficial.
    - EOHHS Medicaid MCO contracts require Chief Diversity, Equity and Inclusion Officers and Health Equity Strategies to address workforce issues in addition to population health management strategies.
- Licensure
    - Review and revision of regulations (e.g., CNA exam, medication aides in home-based settings, nursing faculty requirements, BHDDH Case Manager requirements)
    - Expedited RIDOH licensing processes for military personnel
- Higher Education / Post-Graduate Education: Substantial work in Higher Education / Post-Graduate Education, for example:
    - Wavemaker Fellowship expansion to health care
    - Health Professional Loan Repayment
    - Clinical placement needs assessment
- Data:
    - EOHHS Ecosystem Health Workforce Data Dashboard (data on supply, employment, demographics, earnings, by setting, school, and other variables
    - Proposed expansion of data collection via licensure process
    - 2015 RIDOH Statewide Health inventory (working on 2024 report now)

- Career Awareness: CaringCareers.ri.gov; social media and grassroots campaign; job fairs; VETS and DCYF targeting VEC youth

Key Issues from the National Literature

- Shortages of Healthcare Professionals
- Burnout and high turnover rates
- Aging Workforce
- Technological Changes
- Changing Healthcare Needs
- Workforce Diversity
- Regulatory and Administrative Activities
- Education and Training (and system capacity to train)
- Work-Life Balance
- Safety Concerns
- Population Trends
- Challenges of Behavioral Health – creating gaps in workforce and affecting retention

Challenges drawn from RI Assessments/Reports/Key Informant Interviews

All of these challenges were exacerbated by the pandemic, and all adversely impact workforce recruitment & retention AND timely access to quality care and services.

- Broad range of workforce issues are undermining staff retention and increasing turnover rates, including stress, burnout, work-life balance, physical health issues, and workforce safety. Workforce shortages make it even more difficult for existing staff, which causes more shortages.
- Uncompetitive reimbursement rates and subsequent lower wages impact the state's ability to attract and retain staff. Employers in neighboring states pay higher rates/wages and provide more loan repayment benefits leading to people working out of state.
    - Need annual review to determine market competitiveness for reimbursement rates, wages, and benefits.
- Many jobs in the health care industry are emotionally & physically exhausting. Emotional and physical stress combined with undesirable/unpredictable work hours, often extensive administrative requirements (charting, documentation, prior authorization, etc.), uncompetitive reimbursement rates and wages, health and safety concerns, and limited advancement opportunities make it difficult to attract and retain people in the workforce.
- Need for subsidies and other initiatives that lower higher education costs
    - Need to expand fellowships for primary care providers, NPs, PAs, and other health care professionals
    - Other states have allowed international medical graduates to participate in healthcare in a supervised setting without the need to repeat residency training.
    - Loan repayment programs also can be useful.
- Need for initiatives that lower housing, transportation, and other costs of daily living, which is indirect way of raising wages and being more competitive
- Population Changes – More people leaving the workforce than entering it.
    - Need for culture and system changes as well as greater investments to retool and expand the pool of future healthcare workers beyond the traditional workforce development initiatives
    - Need to better understand and confront the issues at the heart of the "Great Resignation"

- Lack of racial, linguistic, and ethnic diversity in current health care workforce, especially those in licensed positions
- High turnover of full-time and part-time clinical and non-clinical staff are impacting access to care, service delivery, operations, revenue potential, and solvency
    - Clinical: hospital nursing staff (clinical and admin), primary care providers (bi-lingual/culture)
    - Long-term care staffing (home health, nursing homes, assisted living)
    - Behavioral health specialty providers (outpatient, residential, crisis support)
    - Case management/navigators/peers staffing
- High costs associated with recruiting and retaining staff, incentives, and benefit payments
- Need to reduce the administrative burdens for individuals and service providers, such as licensing and credentialing, hinder recruitment, and growth efforts
    - Particularly difficult for foreign-educated health professionals, face cost and admin. burdens to have their credentials recognized
- Lack of a call to serve / "Devotion to Duty"
- Need to expand the capacity and strength of RI's higher education programs – homegrown increases of our providers
    - RI needs a State-run medical school
    - Need to better leverage Brown Medical School to address health workforce challenges
    - Lack of nursing school faculty to meet the demand of people applying for admission
    - Higher education capacity/insufficient faculty concerns
    - Other states have addressed this issue by increasing the number of residency positions.
- Need to develop and implement a robust methodology, including data collection and analysis systems, that identify workforce need and then work to enhance the State's capacity to engage, train, and place people in jobs to meet that need.
- Need to continue to implement an employer-focused approach to workforce development and training that leverages resources and ensures that workforce development/training is appropriate and well-targeted.
- Need to make sure that ear marked resources (e.g., ARPA funds, Stater recruitment/retention dollars, etc.) are expended on intended uses, to increase wages, support loan repayment, training, etc.
- Need to make sure that wage increases do not lead to cuts in program eligibility (WIC, Health Ins. Marketplace Plans) or benefits (e.g., childcare support, SNAP benefits).
- Inconsistent or no enforcement of standing state and fed mandates, such as staffing or service requirements for nursing homes.
- Lack of contingency planning when large numbers of staff retire at the same time.
- Need for additional assessment and state data systems (on-going) that would allow policy and other decision makers understand the capacity and strength of the market (FTE status, job title, spoken languages other than English, etc.).
- Need for regulatory, policy, and program review to reduce barriers to entering the workforce and operating at the "top of their license."
    - For example, policy barriers for family members to be home health aides for their family.
- Expand and enhance Telemedicine by understanding and removing technical, policy, administrative and payment barriers.
- Support for existing workforce to have the ability to secure additional certification (daycare, transportation)

Primary Care

Initiatives to Build On – Existing Rhode Island Activities

- High rate of primary care providers per capita
- High rates of health insurance/coverage
- Proactive approach to innovation (including the work and programs of the Care Transformation Collaborative)
- Collaborative environment facilitated by the State's small size
- Office of the Health Insurance Commissioner (OHIC) Primary Care Spend Obligation
- Supplemental Payments to Designated Primary Care Practices
- Prospective Payment Model
- Administrative Simplification Task Force
- Patient Centered Medical Homes (PCMH) and PCMH Kids programs
- Integration of physical and behavioral health
- Community Health Workers within primary care to address Social Determinants of Health (SDoH), reimbursed by Medicaid
- Accountable Entity program has implemented alternative payment models in primary care practices and can be leveraged for future programs.
- Team based care at RI Primary Care and Coastal Medical
- CTC-RI Leadership training with Scott Conrad.

Key Issues from the National Literature

- Workforce Shortages
- Burnout, Job Dissatisfaction, and High Turnover Rates
- Financial Constraints / Solvency
- Fragmentation of Care
- Access to Care / Barriers
- Changing Patient Demographics
- Technological Changes
- Regulatory and Administrative challenges
- Behavioral Health Integration
- Preventive Care and Health Promotion

Challenges drawn from RI Assessments/Reports/Key Informant Interviews

- Limited access to primary care, especially for new patients, those who do not speak-English, or who are from diverse cultural backgrounds.
- Limited access to primary care physicians; to geriatric care; pediatric care, turnover and recruitment changes. Wait lists and time to new patients.
- Limited engagement in appropriate primary care, particularly for certain groups that are disproportionately impacted by social factors
- Concerns over payment rates. Payments must be sufficient to support team-based care, including medical assistants and front office staff
    - Some evidence that primary care in Rhode Island is reimbursed at rates that do not support compensation that is competitive with neighboring states
    - Primary care is reimbursed and compensated less than most other specialties, which impacts recruitment/retention as fewer med students are choosing primary care

    - Fee-for-service pressure for physicians to see every patient.
- Students who do choose primary care, and are trained in Rhode Island, are not necessarily staying in Rhode Island.
- People's behavioral health needs are impacting patient access and health status as well as service delivery/operations, staff retention/recruitment, and solvency. Not enough BH staff embedded in PC.
- The primary care workforce in Rhode Island is aging and many are considering retirement, exacerbating shortages, and increasing turnover rates
    - To maintain current rates of utilization, RI will need an additional 11% increase in primary care physicians by 2030.
- Clinician burnout is a key concern facing the primary care workforce and is impacting quality of clinical care, practice operations, and staff retention
- Need to enhance primary care workforce training in RI's higher education institutions (also need increased clinical training capacity for medical residents (OB/Pediatric/Behavioral Health & Internal Medicine)
- Need to continue to promote comprehensive team-based care in all PC settings, inc. intensive care mgmt., care coordination, peer support/ CHWs, and linkages to SDOH. Opportunities to do more throughout all practices
- Need to continue to promote integration of behavioral health and primary care. Broader integration of physical and BH healthcare in other agencies besides PC.
- Adolescent services, need for continuum of care and points of access
    - Primary care physicians using ICD10 codes, to bill for counseling and referrals for Alzheimer's.
    - End of life care complex conversations
    - Acumen for billing for value-based payments for PC
- Fragmentation and Care Transitions – access, HIT, placements, etc.
    - Need to study continuity of care transitions to LTSS; complex cases are facing barriers to accessing care as a result preferred provider networks
    - Communities of color are underserved as a result of preferential treatment from primary care networks to LTSS
- Looking at specific populations
    - 19.7% of Hispanic adults do not have a Primary Care Doctor compared to 4.9% of white adults, and 7.3% of adults overall. 13.7% of Hispanic adults compared to 3.9% of White adults report not seeing a doctor in the past 12-Months due to cost.
- Need to continue to promote universal screening for social factors and develop system to link those in need with services in the community
- Need to reduce administrative burdens on primary care (e.g., prior authorization, utilization review)
- Need to develop a public-facing data systems that present longitudinal data on the primary care workforce, practice expenditures, and patient access with comparison to external benchmarks where available
- Need to enhance structures that promote community and service provider engagement in policy/practice innovation
- Dealing with private sector aggregation and ownership of primary care practices. And Minute Clinics, alternative profit-driven PC filling the void. RIDOH ownership survey.
- Use of urgent care a huge point of challenge. (No licensed urgent care in RI – it's an outpatient ambulatory care facility).

- RIDOH doesn't review purchases of primary care
- Payment is insufficient
- There are two odd truths – limited access to PCPs and more PCPs per capita
- There is a lack of data on PCPs and what they are doing
    - Need to assess the workforce for number and FTE of practitioners, FTE spent on administrative tasks at the expense of seeing patients, recruitment, and retention strategies of neighboring states.
- GOV's budget article (workforce data collection) plus existing health care inventory and utilization and capacity study (in progress-not funded)
- APCD has 1,400 PCPs actually submitting claims
- Suggest that inappropriate ED use is highlighted as part of the problem statement
- Missing is technology and how it can lead to burnout- we need to improve technology in the workplace (HIT Advisory Committee)
- Data that should be captured include APCD, Current Care, Health Information Exchange
- We need to talk more about how the focus areas and looking at systems mesh together. We need systems level thinking.
- We need to lower the age s of students we are trying to reach down to middle school and younger to get them interested in healthcare careers.
- CTC-RI Task Force (NPs, MDs, PAs) - January report. Needs include training and retaining PCPs, there is not enough clinical training sites and preceptors
- Rural areas have needs
- Need to gather customer data – what's good and what is not so good
- Delta Dental and NHP have consumer data – NHP consumer data indicates a need for better cultural sensitivity and access to other languages
- Importance of the payment issue
- Payment for team-based care as a model where the savings go back into the team – team-based care promotes better retention and results in less burnout
- Loan Repayment helps the workforce stay in RI
    - There may be an opportunity for cabinet to review and make recommendations around what could broadly be defined as financial incentives for healthcare workforce (Loan Repayment, Tax Credits, Scholarships, Stipends, etc.). Lots of moving pieces and need to look more comprehensively at where the gaps are.
- Increased clinical rotation sites for med students and residents and a state medical school.
    - Consider entering into a compact with UCONN or UMASS for RI residents.

Please note: It has been suggested to the Health Care System Planning Cabinet that the State broaden the Primary Care Area of Inquiry to include other outpatient specialty services. The Cabinet will make a determination on this proposal as the planning process unfolds.

Oral Health

Initiatives to Build On – Existing Rhode Island Activities

- In 2022-2023, Rhode Island raised Medicaid rates for first time since 1992

- Launched Oral Health Assessment and Mouth Care Training virtually, and over 160 CNAs took training in first month
- Held series of Public Health Dental Hygienist Learning Collaborative meetings
- Made Teledentistry technology an allowable use of Home and Community-based Service Funds
- Took steps to improve response capacity for oral health emergencies
- Supported growth of dental workforce, including supporting tuition of Public Health Dental Hygienist (PHDH) training at CCRI, increasing number of those licensed
- Education of both dental and non-dental providers on impact of substance use on oral health, with goal of increasing prevention and referral, and reducing stigma among professionals.
- CCRI has expanded and renovated its dental hygiene clinic and learning lab allowing for a 20% increase in enrollment. This was made possible by a grant from Delta Dental of Rhode Island. Part of the partnership includes an annual scholarship for 10 second year hygiene students who commit to working in Rhode Island for at least one year after graduation. The partnership has received national recognition and is seen as a model for addressing the nationwide shortage of hygienists.
- In addition, through Delta Dental of Rhode Island funding, many of the state's FQHCs have expanded and/or renovated their dental suites, allowing for an expansion in access to care, including Wood River Health, Thundermist (expanded from 12 to 21 operatories in West Warwick), Tri-County and PCHC to name a few.
- Delta Dental is partnering with Rhode Island hospital to launch the state's first oral surgery residency program, which will bring in 2 residents/year along with multiple support staff.

Key Issues from the National Literature

- Limited access to care, especially those who are low-income, uninsured, or underinsured
- High cost of dental care is a substantial barrier to care
- Underutilization of preventive dental care services
- Workforce shortages and a maldistribution of providers, particularly in rural areas
- Need for greater integration of oral health with the overall health care system
- Need for community education and awareness about the importance of oral health
- Regulatory and policy changes needed to improve provider recruitment/retention and encourage innovative care delivery models
- Need to promote adoption of new technology and innovation to care quality and efficiency
- Oral health challenges in individuals with substance use experience, both because of stigma in access, but direct negative impact of medications, including suboxone, on dentition.

Challenges drawn from RI Assessments/Reports/Key Informant Interviews

- Worsening and more costly dental disease. Impact on systemic health, including diabetes, cardiovascular disease, and poor pregnancy outcomes
- Major disparities in dental care access and outcomes
- Shrinking oral health workforce impacting provider availability and access to care
- Oral health needs to be better integrated with existing system transformation efforts
- Historically low Medicaid reimbursement rates limit provider participation in Medicaid program
- Need to address high cost of care
- Limited Use of preventive dental services
- Continued Use of hospital emergency department for both urgent and non-urgent dental services

- Need to promote initiatives to increase oral health literacy and use of evidence-based preventive strategies

Behavioral Health

Initiatives to Build On – Existing Rhode Island Activities

- Creation of 3 key planning documents: the Behavioral Health System Review (2021), RI Behavioral Health System of Care for Children and Youth (2022), and the Rhode Island Infant/Early Childhood Mental Health Plan (2023) – and the soon to be released Adult Behavioral Health Snapshot
- Development of Certified Community Behavioral Health Clinics
- Development of the Mobile Response and Stabilization Services program for children
- Development and Funding of the Overdose Prevention Center
- Peer Recovery Specialist positions reimbursed by Medicaid
- Harm Reduction Services & Supports funded by CDC, Opioid Settlement Dollars, and Opioid Stewardship dollars
- Enhanced Mental Health Psychiatric Rehabilitative Residences (EMHPRRs)
- Expanding behavioral health screening and SBIRT (Screening, Brief Intervention, and Referral to Treatment) programs
- Expanding crisis stabilization units to areas currently underserved
- Prevent sunsetting the behavioral health training program.
- Lifespan has been building and making changes to improve their pediatric behavioral services coordination from avoiding the ED for evaluation to the creation of step-down services from hospitalization and partial hospitalization.
- Delineating Substance Use Disorders and Co-occurring Disorders from Severe Persistent Mental Health Disorders when discussing Peer Recovery Specialists. While all are Behavioral Health Disorders, lived experience is very different. We need to be clear about how PRS are used to support this area of health care.
- RI College community health worker training for behavioral health and dementia.
- Eleanor Slater Hospital and the Rhode Island State Psychiatric Hospital

Key Issues from the National Literature

- Access to Care
- Health Education, Prevention, and Stigma Reduction
- Integration with Physical Health and social services
- Workforce Shortages
- Funding and Reimbursement
- Quality of Care, Including Linguistic and Cultural Competency
- Care Coordination and Transition of Care
- Outreach and Early Intervention
- Crisis Support Services
- Involvement of Those with Lived-Experience, and Their Families/Caregivers

Challenges drawn from RI Assessments/Reports/Key Informant Interviews

Equitable Access to Quality Services (capacity, vulnerable populations, disparities)

- Disparities in access, prevalence/incidence rates and outcomes for the following groups:
    - People who experience resource insecurity
    - African American/Black, Hispanic, and some Asian communities
    - LGBTQIA+ communities
    - Non-English speakers
    - Recent immigrants
    - Those with Intellectual and Developmental Disabilities
    - Veterans
    - New mothers / post-partem care
    - Infant health
- Behavioral health challenges exacerbate workforce issues and strain the entire health and human services system re: access, staffing, operations, and financial solvency
- Limited access to care across the continuum for Adults and Children
    - **For adults**, the most significant shortages are in the higher levels of care, including residential services and full/partial hospital-services. Major gaps in outpatient services too, especially for those in low- and middle-income brackets
    - **For children**, Major challenges, across the full continuum of care, but especially with higher levels of care, a lot of which is currently going out of State or not happening.
        - This is costly to RI and is a particular barrier for families that don't have readily accessible means of travel
        - Depression/anxiety, suicidality, and substance use, particularly among school-aged children
        - Need to expand services in school-settings and ensure that systems are in place to integrate and coordinate these services across the full continuum of care (BH and physical health continuums)
    - Even more limited access for adults and children/families who do not speak English or who have specific service needs due to their cultural background
- Workforce shortages exist across the BH continuum of care, particularly providers who are bi-lingual and able to provide culturally appropriate and practice cultural humility
- Need for greater investment, training, and emphasis on family-centered, evidence-informed, and outcome-driven care
    - Trauma-informed and age-, developmentally-, and culturally appropriate care
- Need for greater investment and strengthening of preventative care and care for those with lower acuity
    - Currently, sense that resources are too focused on those with serious and persistent issues and those with higher acuity
- Need for greater, more sustained investments and strengthening of urgent care, early intervention, and crisis support services.
    - Implementation of crisis and resources of mobile treatment for adults and children
        - Enhance 988 services, to reduce measures of hospital recidivism and reliance on emergency rooms for crisis care.
    - Delays in care and lack of early intervention leading to greater involvement with the Criminal Justice/ACI system

System Transitions, Integration and Coordination

- Need for enhanced programs and systems to support behavioral health navigation

- Need to enhance care transitions within the BH continuum and across other sectors (i.e., primary care, hospitals, long-term care, and housing)
- Continued need to integrate behavioral health and primary care as well as behavioral health services with other services across the continuum of care, including social service system to promote engagement in care
- Need to better integrate in Criminal Justice system and State hospitals systems into the continuum of care discussions; need to think of transitions and re-integration
- Integration of mental health and substance use systems of care, and behavioral health with physical health and the social service system
- Need for access to pediatric psychiatrist for complex patients
- Anecdotally, new mental health workers are not interested in working in those in recovery from addiction who are impoverished. Particularly when there is no shortage of clients seeking therapy from those with the means to fund it. Illuded to in the material that was shared, the basic needs requirements overshadow their ability to make progress and they become discouraged. How can we encourage, prepare, inspire the workforce?
- RI ranks 33rd overall in child behavioral health outcomes. In April 2022, the Rhode Island Chapter of the American Academy of Pediatrics, the Rhode Island Council of Child and Adolescent Psychiatry, Hasbro Children's Hospital, and Bradley Hospital declared a Rhode Island State of Emergency in Child and Adolescent Mental Health.
- Patients are not being adequately assessed for behavioral health needs at time of discharge to LTSS

Administrative Challenges, Policy Reform, and Accountability

- Impact of regulations and licensing requirements are hindering implementation of innovative, cost-effective programing
- Fragmentation in accountability across state agencies and across providers leading to a lack of understanding of roles/responsibilities and limited oversight
    - Services need to be consolidated and more efficiently administered and coordinated
    - Currently behavioral health services administered by 7 different state agencies
- Need for greater, more sustainable, more highly reimbursed funding sources for services across the behavioral health continuum,
    - Especially for intensive-home based services, which are currently grant-funded and not integrated into Medicaid
    - Looking for IHH model for kids that's sustainable over time
    - Explore funding from Restricted Receipts (RR) accounts (alcohol and/or cannabis sales)
- Lack of a statewide data systems to monitor access to care, care transitions, service quality, and sustainability/solvency is limiting sector strength, hindering performance improvement, and threatening solvency
- Need for greater community engagement (service providers, residents, consumer/family groups, and individuals with lived experience)
- Need for payment reform to foster provider stability/sustainability, and create parity in consumer access and provider reimbursement/payment
    - Need to move away from fee for service contracting and use performance measures to create better connection between payments, quality of care, and performance

- Need for reforms in billing practices, particularly for those with co-occurring conditions and who are eligible for services across agencies
- Behavioral health services included in Medicaid MCO contracts.

Acute Hospitals

Initiatives to Build On – Existing Rhode Island Activities

- State directed payments for hospitals
- OHIC Affordability Standards
- Hospital license tax and state directed payments. Need to consider if this should go through state general revenues
- Application of global budgeting
    - Participant experience is that this can kick off a collaborative model that creates competition on the basis of quality. Dr. Wagner is published in this area.
    - This creates a sense of oversight and visibility that encourages different solutions
    - There is concern about the impact global budgeting could have on CMS & ACOs
- Eleanor Slater Hospital and the Rhode Island State Psychiatric Hospital

Key Issues from the National Literature

- Financial Sustainability (Payment rates, high costs, solvency)
- Workforce Challenges (Shortages, High Costs, Burnout/High Turnover)
- Regulatory Compliance and Administrative Challenges
- Adapting to Value-Based Care
- Technology Integration –
- Patient-centered Care
- Health Equity
- Partnerships and Collaborations
- Cybersecurity
- Market Competition /Consolidation
- Need for capital improvements and access to capital funding

Challenges drawn from RI Assessments/Reports/Key Informant Interviews

- High operational costs, combined with high volumes and lack of a diverse payer mix are impacting hospital service delivery, operations, and financial performance. High cost of care is being driven largely by a web of issues relate to workforce, including shortages, recruitment/retention costs, staff burnout/turnover, and per diem/travel labor costs (clinical and non-clinical) (Esp. nursing)
    - Implication of medical training on cost of care, including the direct costs associated with teaching and the unknown indirect costs, such as those incurred from ordering extra tests.
    - There is dissent on the inclusion of this issue, as some participants believe it is or should be addressed at the organizational level
    - Hospitals pay one of the highest taxes, and it adds as much as 6% to the margin
    - Must look at how hospitals spend money (in addition to looking at revenue)
        - Is more than 50% of spending on OH?
        - Reimbursement has not kept up with contracting costs (such as with travel nursing) to address workforce shortages
- High costs also driven by the increasing cost of medical supplies
    - Costs to hospitals are going up 3x more than revenue.

- High patient volumes, lengthier hospital stays, a continued influx of patients who need extended, complex care, and challenges in care transitions, are stressing hospitals in unique ways that can be addressed by reviewing the case-mix index
- Stress, burnout, and lack of work-life balance undermine staff retention and increase turnover rates
- Emergency department triage, particularly the impact of behavioral health is a major challenge
- Care transitions to long-term care, behavioral health care and social services
    - Financial stability, especially in relations to behavioral health
- Need for clearer regulatory frameworks that build trust and promote a common vision for system strength
- Increased investment in primary care, outpatient medical specialty care services, and other public health efforts to support prevention, early identification of health issues, and evidence-informed chronic disease management
- Increased focus on community partnerships across the continuum of care to support a more integrated, coordinated approach, with an eye toward preventing acute illness, reducing readmissions, and promoting appropriate utilization of care
- Enhanced structures and systems that promote collaboration, facilitate partnerships, build trust, allow for information sharing, and fully leverage the resources across the continuum of care.
- Need for aligned information technology, potentially including a consistent electronic medical record among all hospitals and hospital systems in the state
- Need for targeted education and awareness campaigns regarding the appropriate use of emergency departments versus primary care
- Challenges for physicians seeking affordable housing
- Need for resources for the Statewide Health Inventory Program.
- Need for more standardized discharge planning
- Payer mix is heavily Medicare/Medicaid with lower reimbursement. There is a disparity in rates on the commercial side.
- Fees are negotiated, not set. The bigger the health system, the more leverage.
- The model is such that you share in savings, or you take risks.
- Payment reform is critical, but impossible to achieve while navigating the “old” model.
- Lack a place for strategy discussions
- Expansion of pediatric subspecialist physicians
- There needs to be a study/investigation on hospital referrals to LTSS -- preferred networks are gaming the system against patients with complex health needs to not have access to timely care/rehospitalization
- Regulatory framework system needed to achieve the goals this cabinet will identify and implement.
- Use of Emergency Departments for non-emergency care for themselves and their children - sore throats, sinus infections, etc. Is the location of urgent care centers a factor in these choices?
    - Most Rhode Islanders cite lack of open alternatives as reasons for using ER for ‘non-emergency’ care.
- Need for better investment in prevention.
- Need RI Hospital to expand acceptance to Doctor of Osteopathy (DO) students in addition to Medical Doctor (MD) students.

Long-Term Care

Initiatives to Build On – Existing Rhode Island Activities

- FY24 GR investment in Aging and Disability Resource Center, as the primary door people can come through for options
- In 2019, OHA expanded At-Home Cost Share (co-pay) to people ages 19-64 with diagnosis of dementia and/or Alzheimer's.
    - HCBS delays institutionalization. (Lewin report)
- In 2021, the Family Caregiver Alliance of Rhode Island (FCARI) and OHA issued the first Rhode Island State Plan for Family Caregiving.
- Ombudsman Program: Monthly Zoom support for families. Work done by Long Term Care Ombudsman is meant to address complaints by paid caregivers in home settings as well as in facilities, but unclear whether staffing is adequate to allow sufficient oversight.
- Quality Assurance and Performance Improvement (QAPI): Regional group meetings that discuss quality improvements (Quarterly Meetings).
- Money Follows the Person/Nursing Home Transition Initiative (Quarterly Meetings)
- Home Modification Grant Program (GCD)
- PACE can be more of a strategic partner with the State not only today as is- but with the new managed care entities.
    - I think that any state that has a PACE program and long-term care issues should be looking at the lessons learned from its PACE program.
- RI is in the process of implementing Managed LTSS and as part of that transitioning its MMP to a Fully Integrated Dual Special Needs Plan. This is an important initiative and marks significant progress in the LTSS arena undertaken by EOHHS that supports the LTSS sector.
- For complete planning, the long-term care component should reference Older Americans Act-funded programs. These community-based, non-means tested programs, support longer, community-based living prior to a person being poor enough and sick enough to be eligible for Medicaid. These programs include home delivered meals, evidenced based community health education programs, aging well support groups, and more. They are included in the State Plan on Aging created by the Office of Healthy Aging at the direction of the Administration for Community Living.
- We should write the regulations to support the legislation passed years ago for adult supportive living. We should bring long term care and acute care facilities together to discuss issues with boarding patients (patients not accepted in or back to LTC facilities).
- There are relatively few opportunities for consumer directed LTSS in RI Medicaid programs. Consumer direction is an important program element and part of a highly effective LTSS program.

Key Issues from the National Literature

- Financial Sustainability (Payment rates, high costs, solvency)
- Workforce Challenges (Shortages, High Costs, Burnout/High Turnover)
- Regulatory Compliance and Administrative Challenges
- Quality of Care
- Access to Care
- Care Transitions and Care Coordination
- Mental Health and Behavioral Challenges
- Patient and Family Satisfaction

Challenges drawn from RI Assessments/Reports/Key Informant Interviews

Challenges particular to Nursing Facility Sustainability and Financing:

- Rhode Islanders' needs for long-term care are likely to increase, especially due to aging.
- Rhode Islanders are accessing institutional, long-term care earlier than might otherwise be needed, due in part to unsafe housing and inadequate healthcare earlier in the lifecycle.
    - Focus support on home modifications. Lack of safe/affordable housing, impacting individuals aging in their homes. Note, home modification is a durable medical equipment benefit under RI's Medicaid State Plan, but it can be complex to access.
        - RI Livable Homes Modification Grant (Governor's Commission on Disabilities) cannot meet current demand.
- LTSS providers are negatively affected by the workforce problems described above, raising costs, and reducing service availability.
- Rhode Island's long-term care continuum has significant gaps, especially for people with intersecting needs across medical and behavioral care.
    - Group emphasized lack of step-down opportunities to transition children and disabled individuals from institutions to community-based programing.
- Rhode Islanders cannot afford long term care.
- Challenges navigating the long-term care system, especially for those with limited family supports.
    - Need to educate consumers and providers on options to allow for adequate advance planning so fewer families come into the system in crisis.
- Need for statewide data systems to monitor access to care, care transitions, service quality, and sustainability/solvency
- High operational costs related to workforce and supplies.
- Rate review by sector from R.I. Medicaid.
- Reimbursement rates is often identified as a key driver - but it doesn't seem like there is any focus on the waste in the system. Up to 25% of spending is considered waste. https://jamanetwork.com/journals/jama/article-abstract/2752664
- More people are participating in "Medicaid planning" earlier in their lives, so that they spend less time as "private pay" before gaining Medicaid eligibility.
- Minimum staffing ratios for health and safety are increasing costs
    - General concern over the lack of regulation enforcement which directly impacts quality of care – including instances of RIDOH not citing deficiencies after referrals from Ombudsman, although

group flagged that in the absence of RIDOH staff at the table, it wasn't obvious what the full picture was.
    - Group had differences of opinion on minimum staffing ratios.
    - There should be a study to determine the ideal number of beds in the state for the population
    - A formal analysis of future nursing home bed needs, given the recent closures and downsizings.
    - Similar to other workgroups, is there a need for a baseline assessment to better understand and quantify the current and future needs of LTC provider capacity?
- Concerns over nursing facility sale conditions not being enforced.
    - The sale of nursing homes deserves greater scrutiny
- The post-acute care system is in distress, demonstrated by a large home health provider exiting the market due to unsustainable Medicare Advantage rates. This has also affected the skilled nursing home sector as well. There is limited oversight of Medicare Advantage plans.
- The long-term care sector also struggles with underfunding by Medicaid (the primary payer of such services), most recently indicated by significant downsizing by two non-profit nursing homes. These dynamics are creating an access to care issue.

Challenges tied to workforce across long-term care sector:

- Staffing shortages
    - RI needs incentive programs for individuals to enter the space and actually practice, especially CNAs.
        - Included concerns that many new staff entering the workforce required to work third shift (low seniority), leading to individuals not entering the market over family responsibilities.
    - Concern that for-profit facilities may cut corners in their staffing.
    - Trouble competing with hospitals with respect to health care salaries.
- Staff burnout/turnover
- Recruitment/retention costs
- There are 18,000 licensed CNAs in Rhode Island, but many are not practicing. This also suggests there may be opportunities to encourage this population to re-engage with CNA work.
- Workforce shortage/crisis. RI nursing home workforce is down 1,500 staff since the start of the pandemic - or -15.3%.

Challenges tied to gaps in the continuum of care:

- There are approximately 50 adults and 80 children/adolescents in out-of-state placements. There are one to two dozen people in hospitals solely because of a lack of step-down discharge placements.
- Rhode Island lacks an acute LTC setting for aging people and others with significant BH needs who also have medical needs and/or dementia. For those needing a high level of care, this would be a natural role for a geriatric LTC hospital.
- Rhode Island lacks sufficient sub-acute long-term care settings for behaviorally complex or otherwise stigmatized (DOC) populations needing care - neither nursing facilities (NFs) nor Enhanced Mental Health Psychiatric Rehabilitative Residences (eMHPRRs) are meeting the need. For NFs, stigma and

concerns that issues with these patients will drive down NF quality scores are challenges. MHPRRs are not able to meet high medical needs.
    - There is no incentive for home care agencies to take challenging clients
- Natural supports (i.e., family caregivers) lack sufficient support. There are more than 130,000 family/kinship caregivers in Rhode Island.
- Aging housing stock makes it difficult for many Rhode Islanders to age in place.
- Certain geographic areas with higher numbers of older Rhode Islanders may lack nearby services.
    - Lack of Assisted Living programs, especially in particular geographies like South County.
- Increase beds available through Medicaid assisted living program.
- Concern that older and/or disabled adults may lack adequate transportation to services and socialization.
- Lacking access to medical/dental services – example of non-verbal adult with developmental disabilities who needed dental care, and no one would take him as a patient. Issue both for DD and BH disabilities.
- Consider automating level of care determination- this is done is many states- medical information uploaded into a portal. The algorithm kicks up to a staff person any questionable applications. It streamlines the process; creates efficiency for both the state and the client; allows state staff to focus on real issues vs mundane process.
- Add the exploration of developing a continuum of housing for older adults- what can the commercial market help us with? (think Granny pads) and how do we finally get supportive living regulations written so we can create a step below ALF.
- As new rates are set for Medicaid care providers those rates are not applied to At Home Cost Share providers and in a tight home care market, At Home Cost Share participants may face greater delays getting care due to lower reimbursement rates.

Challenges tied to demographic/population issues:

- Inadequate access to healthcare throughout the life cycle leads to an older population that has higher care needs for a longer time.
- Growing population of younger adults needing long term/skilled nursing care due to brain damage resulting from opioid-caused oxygen deprivation. This group has very different needs from older adults.
- Increasing incidence of 'elder orphans' - adults who've reached their senior years but have no loved ones to assist with care when needed. Can present challenges with ADLs and decision making. May result in self-neglect.
- Adults with dementia who lack family caregivers may not receive adequate case management to assist in care planning.
- Affordability is a major challenge for Rhode Islanders. It is also a challenge for the state.
- Rebranding of Adult Day programs to reduce stigma and increase enrollment/participation ("Adult Activity Center").
- Seniors being relied on to support adult children who are underemployed/unemployed. Is this a factor in securing adequate health care?

Policy Suggestions:

- Regional consideration for homecare services/transportation
    - Promote homecare access across the state, including East Bay and South County by incentivizing healthcare services
        - Currently homecare employees may struggle to secure safe and reliable transportation to serve consumers outside of RI's metropolitan areas
        - Lack of available transportation for consumers to make it to appointments leading to more intensive/costly services later.
        - Potential for NFs to co-locate daycare to support workers' childcare needs?
- Educational opportunities for providers/case managers (including but not limited to Conflict Free Case Management (CFCM) in Medicaid) to better understand services available (continuum of care).
- Expanding at home non-clinical services in terms of both services (e.g., adding chore services) and potentially eligibility (e.g., increasing income thresholds) – Office of Healthy Aging At Home co-pay program (increasing eligibility threshold would require 1115 Waiver amendment).
- Value of doing more to survey providers upon licensure/license renewal to see what they are doing for work and what barriers they may face in providing direct care to patients.

Social Service

Initiatives to Build On – Existing Rhode Island Activities

- Establishment of the Health Equity Zones (HEZ)
- Significant Expansion of Community Health Worker Workforce
- Alignment of HEZ and Medicaid to Implement Social Determinants Interventions
- Inclusion of HEZ in Medicaid Waiver and Managed Care Procurement
- Health Equity Zones Scaling and Sustainability
- Medicaid reimbursement for Community Health Workers
- MyNeighborhood Social Determinants Mapping Project
- Housing as Health Care work and the work of the Department of Housing
- RI Foundation Long Term Planning report
- Community Partner Portal at DHS
- Public Health targets within the Cost Trends work
- Strong Medicaid Managed Care Structure (more so than other states)
- Could build on the absentee work being undertaken by the RI Department of Education
- Recent Early Intervention changes with DCYF
- EOHHS is in the process of obtaining federal approval to provide Medicaid-covered SDOH benefits. Currently, Medicaid MCOs can offer In-Lieu-of-Services that include nutritional programs and meal delivery.

Key Issues from the National Literature

- Complexity of Social Determinants
- Need for Resources – and Resource Allocation
- Sustainability
- Data Collection and Integration
- Cross-Sector Collaboration
- Equity and Inclusivity
- Policy and Regulatory Barriers
- Measuring Impact
- Community Engagement
- Policy and Advocacy
- Importance of Economic Security to Families' Lives
- Access to Services – both to healthcare and social services themselves, and technical access

Challenges drawn from RI Assessments/Reports/Key Informant Interviews

- Social, economic, and environmental conditions, also called social determinants of health or SDOH, are the factors that determine 80% health and behavioral health outcomes.
- Requiring clinical care providers to address patient SDOH needs is contributing to provider burnout, largely due to the vertical integration of these services into the health care delivery model vs the horizontal integration of appropriate community supports to address service delivery, coordination, and improvements to local SDOH conditions.

- Treating health-related social needs can reduce the demand for high acuity care but does not address the demand for health and behavioral health services, or the costs associated with the delivery of those services. Reducing the demand for services, the costs associated, and the strain on the healthcare and behavioral healthcare systems will require changes to the social, environmental, and economic conditions of RI communities.
- Social supports and services are best delivered within community settings to ensure those services are proximal to the recipient, culturally appropriate, and connected to other community resources.
- Capacity and infrastructure within communities to support the delivery of social services and supports, the coordination of care amongst community-clinical providers, and the ability to improve community conditions to reduce demand for social, health, and behavioral health services remains under resourced in RI relative to the needs of the population.
- Health Equity Zones provide the state with a scalable community infrastructure to improve the quality of community appropriate social services, to support community-clinical care coordination, and to improve community conditions to reduce demand for services by improving the SDOH factors that drive 80% of health and behavioral health outcomes.
- Success in strengthen any of the other sectors will rely on addressing the social, environmental, and economic factors that impact health access and outcomes
- Economic insecurity is recognized as a leading factor, impacting residents' ability to live healthy, productive lives
- The leading consequences of economic insecurity are unsafe/ unaffordable housing and homelessness, food insecurity, inadequate health and behavioral health care access, and transportation
    - Food insecurity is 3 times more prevalent now than before the pandemic. Food prices have increased 13% from 2021 to 2022. Food deserts continue to be an issue in both rural and urban communities.
    - Approximately 17% of residents are living with at least one 'severe' housing problem. 1 in 8 children in RI are facing hunger. 1 in 3 Rhode Island households can't afford adequate food.
    - 40% Black and Hispanic households are much more likely to be food insecure than whites (25%).
- Major disparities exist depending on where you live as well as your level of economic security, race, ethnicity, age, and other demographic and socio-economic characteristics
- Social services are fragmented with complex eligibility requirements
    - CHWs are trained system navigators
- "In virtually all topic areas from 2019 through 2020, BIPOC Rhode Islanders living in core cities perceived social factors such as access to affordable housing and cost of living as much greater impediments to health and wellbeing than have white Rhode Islanders living in non-core areas."
- Economic insecurity increases child maltreatment. We should highlight family well-being and supports.
- Our health systems, centers, and hospitals don't have funding structures designed to integrate social services. Some of the way we finance healthcare is why it's hard for providers to do this.
- A lot of social services struggle with day-to-day operations but do great work providing service. It's not so easy for them to set up internal processes or tech to take advantage of new initiatives or Medicaid billing. How can we support them?
- Making Medicaid be a part of that discussion- what can and can't be considered a claim, how do you claim it? Expanding our 1115 waiver – the potential to follow a lot of great models across the country.

- Ideally, a pool of resources that can be prioritized and funded in ways that work for social service organizations that allow to serve whole families and communities.
- Including Health information technology should be included, too.
- It is imperative to integrate a robust child and family well-being lens into our planning efforts. This necessitates a comprehensive acknowledgment of the intersection between social determinants of health and families with children, particularly those either at risk of entering or currently engaged with the child welfare system. Central to this approach is recognizing the profound impact of inadequate concrete and economic supports on the prevalence of child maltreatment. By addressing these systemic deficiencies and bolstering the availability of services tailored to support young people, including initiatives focused on infant mental health, we fortify our capacity to safeguard the welfare of vulnerable children and families. This holistic perspective underscores the interconnectedness of various social factors and underscores the imperative to adopt multidimensional strategies that address the complex needs of those navigating the child welfare landscape.
- SDOH is not even on the radar for LTSS reform -- needs to change
- Access to EI, Head Start, housing assistance, food pantries, and programs like Big Brothers/Big Sisters, and Parents as Teachers
- Medicare reimbursements are listed as a benefit throughout this document. However, initiating a relationship with someone in need by asking for an insurance card, and dedicating a large portion of the interaction and follow up by CHWs and PRS to the requirements of the insurance transaction before and after degrades the effectiveness of the service.
- Study on access barriers

Appendix 1: Sources of Information, by Area of Inquiry

1. Health Care Workforce

Social and Human Services Program Review – Access

Health and Human Services Workforce Transformation (2023)

2022 Financial Impact Analysis on Hospitals in Rhode Island

2. Primary Care

Primary Care in Rhode Island: Current Status and Policy Recommendations (Dec 2023)

Statewide Health Inventory 2015 (and coming in 2025)

3. Behavioral Health

RI Behavioral Health System Review Technical Assistance (July 2021)

Social and Human Services Program Review – Access to programs (OHIC 2023)

State of RI Strategic Plan for Substance Misuse Prevention 2020-2024

Rhode Island Behavioral Health System of Care for Children and Youth (2022)

Rhode Island Infant and Early Childhood Mental Health Plan (2023)

4. Acute Hospitals

2022 Financial Impact Analysis on Hospitals in Rhode Island

Health and Human Services Workforce Transformation (2023)

2022 Financial Impact Analysis on Hospitals in Rhode Island Health and Human Services Workforce Transformation – Manatt Health, for the Rhode Island Foundation (2023)

5. Long-Term Care

Long Term Services and Supports Evaluation of Rebalancing Strategies (2016)

Rhode Island Healthy Aging Data Report (2020)

AARP LTSS Scorecard (2023)

AARP Vital Voices: Issues That Impact Rhode Island Adults Age 45 and Older (2023)

Rhode Island State Plan for Family Caregivers (2021)

Rhode Island Aging in Community LTCCC Subcommittee Report (2016)

2023 Aging in Community Progress Report and Covid Lookback

6. Social Service Sector

Social and Human Services Program Review – Access

Health and Human Services Workforce Transformation (2023)

2022 Financial Impact Analysis on Hospitals in Rhode Island